REHABILITATION SERVICES

Table of Contents

GENERAL CRITERIA 2

TERMS AND ABBREVIATIONS 2

PRIOR AUTHORIZATION REQUIREMENTS FOR MEDICAID REIMBURSEMENT OF INPATIENT REHABILITATION SERVICES 3

QUICK REFERENCE FOR REHABILITATION SERVICES 5

SPINAL INJURY -- PARAPLEGIA 6

SPINAL INJURY -- QUADRIPLEGIA 6

TRAUMATIC BRAIN INJURY (TBI) 7

STROKE (CVA) 7

OTHER DIAGNOSIS 8

GENERAL CRITERIA

ALL rehabilitation services require prior approval from Medicaid for reimbursement of services. This attachment to the Hospital Manual specifies the requirements and criteria for rehabilitation services.

TERMS AND ABBREVIATIONS

The following is an explanation of column heading and codes found on the Rehabilitation Services Tables.

DRG Diagnosis Related code

DIAGNOSIS Description of the DRG code

AGE Medicaid covers rehabilitation services from birth through any age.

PA Pre-approval is required by Medicaid. Refer to PRIOR AUTHORIZATION REQUIREMENTS FOR MEDICAID REIMBURSEMENT OF INPATIENT REHABILITATION SERVICES on next page.

DISEASE SPECIFIC CRITERIA Specific information and criteria required by Medicaid before the item will be reimbursed.

OUTLIER Description of the outlier threshold

COMMENTS Reserved for future use

PT Physical Therapy

OT Occupational Therapy

SLP Speech Language Pathology, Speech Therapy

FIM Functional Independent Modifier, a measurement tool

ASIA American Spinal Injury Association Classification Score, a measurement tool

RANCHO Rancho Los Amigos Scales of Cognition

WISCI Walking Index for Spinal Cord Injury

ABS Agitated Behavior Scale

PRIOR AUTHORIZATION REQUIREMENTS FOR MEDICAID REIMBURSEMENT OF INPATIENT REHABILITATION SERVICES

A. Inpatient hospital intensive physical rehabilitation services are covered Medicaid services, as specified in R414-2B, Utah Administrative Code. Effective January 1, 2009, rehabilitation services will be manually reviewed by Medicaid Program Integrity staff following the provider evaluation of patient rehabilitation potential.

B. Outpatient rehabilitation is limited to individual clients who qualify for the service. Prior authorization may be given based on established criteria. Outpatient therapy (OT, PT, SLP) is an optional service with a limited number of visits. Inpatient rehabilitation therapy service is intended to provide the therapy necessary to allow the patient to function without excessive outpatient followup therapy; and therefore, the maximum therapy service the patient can have under the DRG should be provided. Failure to provide this needed therapy during the patient's inpatient stay may affect the patient because adequate outpatient therapy visits may not be available.

C. For approval, inpatient rehabilitation services must meet the following criteria:

(1) The patient is medically/surgically stable and requires 24-hour nursing care or supervision by a registered nurse with specialized training in rehabilitation.

(2) Due to the patient's potential risk of significant changes in physical or mental states, close supervision by the rehabilitation team under the supervision of a rehabilitation physician specialist is required.

(3) This is the patient's first admission, or the patient has developed a new problem which now meets medical necessity for rehabilitation admission.

(4) The patient has a reasonable expectation of improvement in his/her activities of daily living which are appropriate for his/her chronological age and development that will be of significant functional improvement when measured against his/her documented condition at the time of the initial evaluation.

(5) The patient requires rehabilitation evaluation and management services in intensity, frequency, or duration that qualify the patient for an inpatient rehabilitation stay by a (i.e. FIM score, ASIA score, Rancho score, Disability Rating Scale (DRS), Walking Index for Spinal Cord Injury (WISCI), Agitated Behavior Scale) measurement tool which provides an objective measurement of the initial evaluation and lends itself to documenting progression toward rehabilitation goals.

(6) For review of prior authorization approval, the following medical record documentation must be submitted:

a. The physiatry or physical medicine history and physical with the rehabilitation, short and long term goals.

b. Nursing assessment.

c. The hospital discharge summary, if available, with rehabilitation plan and number of hours of therapy estimated for any given discipline. Note: discharge summary is often not available at the point of request for prior authorization, but is required for retro reviews of the patient record.

d. Documentation supports at the time of admission to the rehabilitation unit, that the patient's physical, cognitive, and sensory capacity will allow active participation in an intense rehabilitation program (5 ½ days/week) which includes a minimum of three

hours of physical therapy and at least one other discipline (i.e. OT, Speech, etc.) which will restore function rather than maintain existing function.

1. Documentation of the functional independent modifier (FIM) score for OT, PT and Speech with the discharge goals for each discipline must be submitted. Note: If available, the audiology record should be submitted with the request for Speech Therapy.
2. Measurement scores in addition to the FIM are required for stroke, head, or spinal cord injury.

D. Rehabilitation services are non-covered when: (One)

(1) The patient is not medically stable or requires acute inpatient hospital services.

(2) The patient's condition and prognosis meets the requirements of placement in a long-term care facility, skilled nursing facility, or outpatient rehabilitation service.

(3) Deconditioning (i.e. cardiac or pulmonary rehabilitation).

(4) Bilateral hip or bilateral knee replacement surgery is completed at patient request. Documentation must support the medical necessity for completing either procedure bilaterally.

E. Beginning January 1, 2009, prior authorization based on the appropriateness of the rehabilitation admission will be determined by the initial FIM score and other validated measurement tools. The physician or his/her designee must initiate the request for prior authorization no later than the 5th working day after admission to the Rehabilitation Unit. The patient must be eligible at the time for Medicaid. The request must be sent in by FAX with all the pertinent information outlined in item C and D. If request is submitted without all required documentation, the request will start from the date of receipt rather than date of admission. Reminder: Coverage requirements apply ONLY when the Medicaid client is assigned to a Primary Care Provider or not enrolled in a managed care plan. Medicaid does NOT process Prior Authorization (PA) requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting PA for services to a client enrolled in a managed care plan will be referred to that plan.

Fax number is: (801) 536-0161

F. At receipt of the FAX, a decision will be made by Medicaid staff regarding the appropriateness of the admission. The provider will be informed by fax of the decision. A letter of approval or denial status will be mailed to the provider.

G. Notice of Rights

(1) The Medicaid agency will give advance notice in accordance with State and Federal regulations whenever payment is not approved for services which prior authorization was requested. The notice will specify (a) the service(s) and reason(s) for which the authorization was not granted, (b) the regulations or rules which apply, and (c) the appeal rights of the provider.

(2) The physician and/or hospital may not charge the patient for services that are denied (a) because the provider failed to advise the patient that the services were not a covered Medicaid benefit, (b) because the provider failed to follow prior authorization procedures, or (c) because payment has been denied. The provider may charge the patient for services that are not covered by Medicaid only when the provider has advised the patient in advance that the services are not covered and the patient has agreed in writing to pay for the services. Refer to Section 1, Chapter 6 - 9, *Exceptions to Prohibition on Billing Patients*.

QUICK REFERENCE FOR REHABILITATION SERVICES

DRG	SERVICE	PA	CRITERIA
800 801 802 803 804	All rehab services	yes	■Physician or his/her designee must initiate the request for PA no later than the 5th working day after admission to the Rehab Unit. Required written documentation must include: -physiatry history and physical, inpatient discharge summary, if available. -nursing assessment. -hospital discharge plan with the short and long term rehabilitation goals including the expected number of hours of therapy estimated for any given discipline. -documentation at the time of admission that the patient's physical, cognitive, and sensory capacity allows active participation in an intense rehabilitation program (5 ½ days/week) which includes a minimum of three hours of physical therapy and at least one additional discipline (i.e. OT, speech therapy) which will restore function rather than maintain existing function. -a copy of functional independent modifier (FIM) score for OT, PT, and Speech Therapy rehabilitation admission status with discharge goals. Note: Submit audiology record if available with Speech Therapy FIM.

SPINAL INJURY -- PARAPLEGIA

DRG	DIAGNOSIS	AGE	PA	DISEASE SPECIFIC CRITERIA	OUTLIER	COMMENTS
800	Spinal injury resulting in paraplegia	all	yes	Patient has paralysis of two limbs or half of the body related to trauma or disease of the spinal cord. The ASIA score or other standardized measurement tool must be in the record. May be complicated by: ■Pressure sores ■Urological complications (UTI, dysreflexia) ■Respiratory complications ■Contractures ■Spinal/skeletal instability	The outlier threshold is calculated by multiplying the ALOS by 130%.	The patient is mentally and physically ready to learn adaptive techniques, transfer skills, and equipment use appropriate for the level of injury. There are well defined treatment goals.

SPINAL INJURY -- QUADRIPLEGIA

DRG	DIAGNOSIS	AGE	PA	DISEASE SPECIFIC CRITERIA	OUTLIER	COMMENTS
801	Spinal injury resulting in quadriplegia	all	yes	Patient has paralysis of all four limbs. The ASIA score or other standardized measurement tool must be in the record. May be complicated by: ■Pressure sores ■Urological complications (UTI, dysreflexia) ■Respiratory complications ■Contractures ■Spinal/skeletal instability	The outlier threshold is calculated by multiplying the ALOS by 130%.	The patient is mentally and physically ready to learn adaptive techniques, transfer skills, and equipment use appropriate for the level of injury. There are well defined treatment goals

TRAUMATIC BRAIN INJURY (TBI)

DRG	DIAGNOSIS	AGE	PA	DISEASE SPECIFIC CRITERIA	OUTLIER	COMMENTS
802	Traumatic brain injury	all	yes	The Rancho Classification score must be in the medical record. Must have documented two or more neurological deficits such as: 1. Dysphagia 2. Dysphasia 3. Paralysis 4. Visual disturbances 5. Cognitive deficit	The outlier threshold is calculated by multiplying the ALOS by 130%.	Documentation of well defined treatment goals for functional improvement. The patient is an evolving Rancho 3 or Rancho 4-6 with behavior management issues.

STROKE (CVA)

DRG	DIAGNOSIS	AGE	PA	DISEASE SPECIFIC CRITERIA	OUTLIER	COMMENTS
803	stroke (cardiovascular accident)	all	yes	1. Treatment must begin within 60 days after onset of stroke. 2. Patient has sustained focal neurological deficit. 3. The rehabilitation service is for a separate focal CVA site than a previous admission.	The outlier threshold is calculated by multiplying the ALOS by 130%.	Well defined treatment goals for functional improvement are documented.

OTHER DIAGNOSIS

DRG	DIAGNOSIS	AGE	PA	DISEASE SPECIFIC CRITERIA	OUTLIER	COMMENTS
804	Other Conditions which may require intensive inpatient rehabilitation program: 1. Neurological Defect: • Amyotrophic lateral sclerosis (ALS) • Guillain-Barre Syndrome • Multiple Sclerosis • Myelopathy (transverse myelitis infarction) • Myopathy • Parkinson's Disease 2. Congenital deformity (i.e. following dorsal rhizotomy) 3. Complex fractures (i.e. hip) 4. Amputation 5. Post neurosurgery of Brain or Spine (i.e. tumor) 6. Burns 7. Major multiple trauma (i.e. fractures, amputation) 8. Post meningo-encephalitis	all	yes	Patient with marked physical impairment secondary to a variety of problems such as trauma, surgery, chronic disease, and malnutrition or a combination of factors that can be expected to improve with a comprehensive physical restoration program. 4. Amputation: The patient must have been mobile prior to the injury. Supportive documentation must substantiate a rehabilitation stay will be beneficial to the patient. The stump must be healed to the point that physical therapy and rehabilitation education can be accomplished. 5. Post neurosurgery: Must have complicating medical condition which requires close medical supervision by a physician with resulting muscular skeletal deficit. 6. Burns: Disability due to burns involving at least 15% of the body.	The outlier threshold is calculated by multiplying the ALOS by 130%.	